

General

Guideline Title

The management of depression in patients with cancer.

Bibliographic Source(s)

Li M, Kennedy EB, Byrne N, Gerin-Lajoie C, Green E, Katz MR, Keshavarz H, Sellick SM, Management of Depression in Patients with Cancer Expert Panel. The management of depression in patients with cancer. Toronto (ON): Cancer Care Ontario (CCO); 2015 May 11. 96 p. (Program in Evidence-Based Care Guideline; no. 19-4). [170 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Rodin G, Katz M, Lloyd N, Green E, Mackay JA, Wong R, Supportive Care Guidelines Group. The management of depression in cancer patients: a clinical practice guideline. Toronto (ON): Cancer Care Ontario (CCO); 2006 Oct 17. 39 p. (Evidence-based series; no. 13-6). [78 references]

The Program in Evidence-based Care (PEBC) Guideline over time will expand to contain new information emerging from their reviewing and updating activities.

Please visit the [Cancer Care Ontario \(CCO\) Web site](#) for details on any new evidence that has emerged and implications to the guidelines.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

Recommendation 1. Screening of Patients with Cancer for Distress or Depression

Patients with cancer should be screened for depression. Many cancer programs incorporate depression screening into Screening for Distress programs. A clear diagnosis of depression is required to guide treatment. See Appendix 3 in the original guideline document for psychological features that distinguish the continuum of depressive symptoms. To improve health outcomes, screening must be linked to effective interventions.

Recommendation 2. General Management Principles

The following general management principles are recommended:

1. Provide psychoeducation about the nature of depression in patients with cancer and consider providing handouts such as those published by

the National Cancer Institute.

2. Inform patients about the impact of depression on cancer outcomes, including reduced quality of life, intensification of physical symptoms, longer hospital stays, and reduced survival rates.
3. Destigmatize clinical depression in cancer by framing it as a serious problem requiring treatment, rather than as a personal weakness or failure to cope.
4. Investigate medical contributors to depression such as hypothyroidism, or vitamin B₁₂, folate, or iron deficiency.
5. Assess and optimize cancer-related physical symptom control.
6. Encourage family members' involvement and education, communication with family members regarding prognosis, and resolution of problems within the support network.
7. Discuss treatment options, attending to patients' preferences and previous treatment experiences.
8. Consider use of a validated depression rating scale to monitor change over time (see Appendix 2 in the original guideline document).

Recommendation 3. Pharmacological or Psychological/Psychosocial Interventions

Patients with cancer who are diagnosed with major depression may benefit from pharmacological or psychosocial interventions either alone or in combination.

Recommendation 4. Depression Severity and a Stepped Care Approach

Interventions for depression in patients with cancer should be delivered according to a stepped care model. This involves assessment of the severity of depression for each patient (see Appendix 3 of the original guideline document), provision of support and psychoeducation to all patients, delivery of lower-intensity interventions for persistent subthreshold and mild to moderate depression, followed by progression to higher-intensity interventions for nonresponsive or moderate to severe depression (see Figure 2 in the original guideline document). Low-intensity psychosocial interventions include structured group physical activity programs, group-based peer support or self-help programs, and guided self-help programs based on cognitive behavioural therapy (CBT), behavioural activation, or problem-solving techniques. High-intensity psychosocial interventions include individual or group CBT, behavioural couples' therapy, and individual or group supportive-expressive psychotherapies.

Recommendation 5. Collaborative Care Interventions

Collaborative care interventions should be considered for patients with cancer who are diagnosed with major depression. Collaborative care involves active collaboration between the oncologist or primary care provider and a patient care manager (nurse, social worker, psychologist), with pharmacological treatment supervised by a consulting psychiatrist as needed. The care manager provides psychoeducation, delivers structured psychosocial interventions such as behavioural activation or problem-solving therapy, and monitors progress. Weekly case review meetings are held to adjust treatment plans for inadequate improvement. These are multi-component interventions, which can be offered at a range of intensity levels, depending on the presentation of the patient and local resources. They typically include measurement-based care, and involve increases in the level or intensity of intervention as needed according to the principles of stepped care.

Recommendation 6. Specialist Referral

In a stepped care model, referral to psychosocial specialists, including mental health specialists, should occur in the following instances:

1. When there is risk of harm
2. In complex psychosocial cases
3. Where the patient experiences persistent symptoms after initial intervention
4. When diagnosis is unclear
5. For delivery of specific psychotherapies requiring specialized training

Recommendation 7. Selection of Psychological Therapies

Because there is insufficient evidence for superiority of one modality over another, selection of psychological therapy should be based on patient factors and local resource availability.

- Among patients with cancer presenting with depressive symptoms, most are mild to moderate. The stepped care model recommends that psychological interventions be considered first for mild to moderate depression.
- Psychological therapies should be delivered by health care professionals competent in the modality, but non-mental health specialists can be trained in basic psychosocial interventions.

Recommendation 8. Use of Antidepressant Medication

Do not use antidepressants routinely to treat subthreshold depressive symptoms or mild depression, due to the higher risk-benefit ratio at this level of depression severity. Antidepressant medication should be considered first for severe depression. Table 1 of the original guideline document provides practical guidance on selecting commonly used antidepressants for patients with cancer (see Appendix 5, Appendix 6, and Appendix 7 in the original guideline document for further guidance on antidepressant prescribing practices, classes of antidepressants for use in cancer patients, and information on antidepressant drug interactions, respectively). In clinical practice, a selective serotonin reuptake inhibitor (SSRI) such as citalopram/escitalopram should be the first resort due to best tolerability and the least potential for drug interactions.

Clinical Algorithm(s)

An algorithm titled "Quick reference management algorithm" is provided in the original guideline document.

Scope

Disease/Condition(s)

- Major depression
- Cancer

Guideline Category

Counseling

Management

Screening

Treatment

Clinical Specialty

Family Practice

Internal Medicine

Oncology

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Nurses

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Social Workers

Guideline Objective(s)

To improve the quality and consistency of the management of depression for patients with cancer in Ontario

Target Population

Adult patients with cancer who are diagnosed with a major depressive disorder based on a structured diagnostic interview, or who have a suspected depressive disorder based on meeting a threshold on a validated depression rating scale

Interventions and Practices Considered

1. Screening for distress or depression
2. General management principles
 - Providing psychoeducation about the nature of depression
 - Informing patients about the impact of depression on cancer outcomes
 - Destigmatizing clinical depression in cancer
 - Investigating medical contributors to depression such as hypothyroidism, or vitamin B₁₂, folate, or iron deficiency
 - Assessing and optimizing cancer-related physical symptom control
 - Encouraging family members' involvement and education
 - Discussing treatment options and attending to patients' preferences and previous treatment experiences
 - Use of a validated depression rating scale to monitor change over time
3. Choice of pharmacological or psychological/psychosocial interventions alone or in combination
4. Use of a stepped-care management approach based on depression severity
5. Collaboration between the oncologist or primary care provider and a patient care manager (nurse, social worker, psychologist)
6. Referral to psychosocial specialists, including mental health specialists
7. Selection of psychological therapies
8. Use of antidepressant medications (citalopram/escitalopram, venlafaxine/desvenlafaxine, bupropion XL, duloxetine, mirtazapine)

Major Outcomes Considered

- Depression severity (reduction in severity according to a validated depression rating scale)
- Cases of depression (reduction in cases measured by structured diagnostic interview)
- Depression response (50% reduction in score from baseline on a validated depression rating scale)
- Depression remission (score after treatment is below a predetermined significant threshold on a validated depression rating scale)

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

The members of the Working Group began by searching for existing practice guidelines as a potential source of recommendations that could be adapted or endorsed. Guidelines were eligible to be used for this purpose if they were based on a systematic review of the literature that was more current than the previous version of this guideline, or on a methodologically sound formal or informal consensus process. If no such guidelines were found, or if gaps remained, the members of the Working Group agreed to consider adopting an evidence base from one or more appropriate systematic reviews. Finally, if no systematic reviews were found that addressed the research questions of interest or were sufficiently up to date,

then the members of the Working Group planned to draw on evidence from randomized controlled trial (RCTs) and conduct an original meta-analysis, if feasible. For the sake of efficiency, the search for guidelines, systematic reviews, and primary studies was conducted simultaneously.

Selection of Clinical Practice Guidelines, Systematic Reviews, and Randomized Controlled Trials

The electronic databases MEDLINE, EMBASE, PsycINFO, and the Cochrane Library were searched for guidelines, systematic reviews, and RCTs that were published after the final search date of the previous version of this systematic review (June 2005) and before January 2015, using the search terms listed in Section 2, Appendix 1 of the original guideline document. In addition, files of the Working Group members were searched. Web sites of international guideline developers, Canadian provincial and national cancer agencies, and CancerViewCanada (<http://www.cancerview.ca>) were searched for existing evidence-based practice guidelines using the word "depression." See Section 2, Appendix 2 in the original guideline document for a complete list of databases and associations that were searched. Shortly before the guideline was completed, an additional search from March 2013 to January 2015 was conducted to ensure the currency of the evidence base.

Documents were screened by the project research methodologist. Full-text guidelines and/or systematic reviews that appeared to meet the selection criteria were retrieved, and the full set of selection criteria, including whether the population, intervention, comparisons, and outcomes of interest were appropriate was applied independently by the methodologist and by the lead author of the Working Group. In cases of disagreement, consensus was achieved through discussion.

Inclusion Criteria for Practice Guidelines and Systematic Reviews

Practice guidelines and systematic reviews were considered for inclusion when the population, intervention, comparisons, and outcomes of interest aligned with the objectives of the study. The inclusion criteria were limited to guidelines that received a high score on the rigour of development domain of the Appraisal of Guidelines Research and Evaluation (AGREE II) instrument. Section 2 in Appendix 4 of the original guideline document has a list of excluded guidelines and reasons for their exclusion. The systematic reviews were used as sources of RCTs that met the inclusion criteria for RCTs (see below).

Inclusion Criteria for Randomized Controlled Trials

Primary studies were eligible if they were full publications (not abstracts), included a randomized comparison (either blinded or nonblinded) with a treatment group compared with another treatment group or a placebo/usual care control group. Nonrandomized or single-arm trials, narrative reviews, retrospective observational studies, case-control studies, case series, before-and-after studies, letters, and editorials were excluded. Non-English-language publications were excluded because full-text translation resources for these items were not available.

Trials were only included if all individuals in the study population met a cut-off for diagnosis of depression on a validated depression rating scale or structured clinical interview. Therefore, depression prevention trials were excluded. This also meant that studies for which depression was not an inclusion criterion were not eligible, as was the case with most studies in which depression was not the primary outcome. However, studies where analyses were conducted on a subgroup of patients that met the criteria for depression were considered eligible. There was no minimum number of patients defined for study eligibility.

Refer to the "Results" section of the original guideline document for information on studies retrieved through the literature searches.

Number of Source Documents

Guidelines: Two guidelines met the inclusion criteria.

Randomized Controlled Trials: 8 pharmacological studies, 9 psychological intervention studies, and 8 collaborative care interventions were included from the systematic reviews.

Refer to the "Results" section in the original guideline document for discussion of the included studies.

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Meta-Analysis

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Data Extraction and Quality Assessment

After an initial screen to ensure that guidelines met the basic inclusion criteria, a quality assessment was conducted by one methodologist and one or two members of the Working Group independently, using version II of the Appraisal of Guidelines for Research and Evaluation (AGREE II) tool. Systematic reviews that met the basic inclusion criteria were assessed for quality using the Assessment of Multiple Systematic Reviews (AMSTAR) tool.

The Cochrane Risk of Bias Tool was used to assess the quality of randomized controlled trials (RCTs). Other study characteristics such as measurement scales used and outcome measures were extracted. Data extraction was verified by a project research assistant. All authors reviewed and discussed a draft of the evidence summary. Strengths and weaknesses were evaluated with the aim of characterizing the quality of the evidence base as a whole, without the use of a scoring system or cut-offs.

Statistical Analysis

Meta-analyses of response and remission outcome measures were conducted with Review Manager software (RevMan version 5.3, Cochrane Collaboration). Random effects models were used for all analyses, with the underlying assumption that different studies estimate different, yet related, intervention effects. Analyses were conducted by time period from the start of treatment in order to compare the short- and long-term effectiveness of interventions. Definitions of short-term and long-term were arrived at by consensus of the members of the Working Group based on the time frames used in the individual studies. Results from intent-to-treat analyses were combined with completer analyses, because a previous analysis of studies of depression in physically ill populations showed that this did not affect the results.

Where available, estimates that had been adjusted for potential confounding variables were used in the meta-analyses. A probability level for the chi-square statistic of $\leq 10\%$ ($p \leq 0.10$) and/or an I^2 of greater than 50% were considered indicative of statistical heterogeneity between studies. In the meta-analyses, effect sizes are expressed as odds ratios (ORs) for dichotomous variables and standardized mean differences for continuous variables, with 95% confidence intervals (CIs) around the estimates. Where standard deviation was not available it was calculated using the standard error estimates that were reported in the study results.

For the pharmacological interventions, all classes of antidepressants were combined, because a previous subgroup analysis according to antidepressant class conducted on 51 studies of individuals with a physical illness suggested that selective serotonin re-uptake inhibitors (SSRIs), tricyclic antidepressants (TCAs), and mianserin/mirtazapine were effective in the treatment of depression in the physically ill compared with placebo, and the Working Group's members did not have reason to believe that this conclusion would not apply to the specific population of physically ill patients addressed in this review.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Formation of Working Group

Cancer Care Ontario's Psychosocial Oncology Program asked the Program in Evidence-Based Care (PEBC) to develop a guideline on the management of depression in patients with cancer. A Working Group was identified, consisting of members with expertise in psychiatry, psychology, nursing, and health research methodology.

Guideline Review

Almost all PEBC document projects begin with a search for existing guidelines that may be suitable for adaptation. This includes a wide spectrum of potential activities from the simple endorsement, with little or no change, of an existing guideline, to the use of the evidence base of an existing guideline with *de novo* recommendations development.

For this document, a search for guidelines was conducted using the resources listed in Section 2, Appendix 2 of the original guideline document. Only guidelines published after 2005 were considered. Guidelines that were considered relevant to the objectives and the research questions were then evaluated for quality using the Appraisal of Guidelines for Research and Evaluation (AGREE II) instrument.

Evidentiary Base Development and Initial Recommendations

Using the objective of the guideline, a search for existing systematic reviews and a systematic review of the primary literature were conducted. The Working Group began with the recommendations from the original version of this guideline, and then considered the new evidence and determined that new recommendations were required.

Research Question

What is the efficacy of treatment (pharmacological and/or psychological) for depression in the adult cancer population?

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Internal Review

Program in Evidence-Based Care (PEBC) documents undergo internal review by an Expert Panel and the Report Approval Panel (RAP). The Working Group was responsible for incorporating the feedback and required changes of both of these panels, and both panels approved the document before it was sent to External Review.

Expert Panel Review and Approval

The Expert Panel for this document consisted of members with expertise in aspects of psychosocial oncology. The members of this group were required to submit conflict of interest declarations prior to reviewing the document. For the document to be approved, 75% of the Expert Panel must cast a vote or abstain, and of those that voted, 75% must approve the document. At the time of the voting, panel members could suggest changes to the document, and possibly make their approval conditional on those changes. In those cases, the Working Group was responsible for considering the changes, and if those changes could be made without substantially altering the recommendations, the altered draft would not need to be submitted for approval again. The nine-person Expert Panel was asked to review the document from October 15, 2014 to November 21, 2014. Responses were received from seven Expert Panel members, all of whom approved the document. Suggestions for changes were made, as outlined in Section 3, Table 1 of the original guideline document.

Report Approval Panel Review and Approval

The purpose of the RAP review is to ensure the methodological rigour and quality of PEBC documents. The RAP consists of two clinicians with

broad experience in clinical research and guideline development, and the Director of the PEBC. RAP members must not have had any involvement in the development of the guideline prior to Internal Review. All three RAP members must approve the document, although they may do so conditionally. If there is a conditional approval, the Working Group is responsible for ensuring the necessary changes are made, with the Assistant Director for Quality and Methods, PEBC, making a final determination that the RAP's concerns have been addressed.

The RAP reviewed this document between October 15, 2014 and November 28, 2014, and approved the document, with changes suggested as outlined in Section 3, Table 2 of the original guideline document.

External Review by Ontario Clinicians and Other Experts

The PEBC external review process is two pronged and includes a targeted peer review that is intended to obtain direct feedback on the draft report from a small number of specified content experts and a professional consultation that is intended to facilitate dissemination of the final guidance report to Ontario practitioners. Refer to the PEBC Handbook (<https://www.cancercare.on.ca/common/pages/DownloadFile.aspx?itemid=50876>) for additional detail.

Targeted Peer Review

Eight targeted peer reviewers from Ontario, other Canadian provinces, the United States and Europe who are considered to be clinical and/or methodological experts on the topic were identified by the members of the Working Group. Three of these individuals provided peer review of the document between January 29, 2015 and March 6, 2015. Their affiliations and conflict of interest declarations are in Section 3, Appendix 1 of the original guideline document. Key results of the feedback survey are summarized in Section 3, Table 3 of the original guideline document. The main written comments from targeted peer reviewers and the Working Group's modifications/actions/responses are summarized in Section 3, Table 4 of the original guideline document.

Professional Consultation

Feedback was obtained through a brief online survey of health care professionals and other stakeholders who are the intended users of the guideline. Nurse practitioners, nurses, primary care physicians, psychologists and psychiatrists as well as those with an interest in palliative care in the PEBC database were contacted by email to inform them of the survey. The survey was also emailed to professional organizations, including the Canadian Association of Psychosocial Oncology, Canadian Partnership Against Cancer, deSouza Institute for Oncology Nursing and the Ontario Psychological Association. All participants were from Ontario, with the exception of one individual each from the provinces of Manitoba and Quebec. Forty-eight responses were received between February 3, 2015 and March 2, 2015. The key results of the feedback survey are summarized in Section 3, Table 5 of the original guideline document. The main comments from the professional consultation and the Working Group's modifications/actions/responses are summarized in Section 3, Table 6 of the original guideline document.

Conclusion

This Guideline report reflects the integration of feedback obtained through the external review process with final approval given by the Management of Depression in Patients with Cancer Expert Panel and the Report Approval Panel of the PEBC. Updates of the report will be conducted in accordance with the PEBC Document Assessment and Review Protocol, which can be obtained by contacting the PEBC offices at ccopgi@mcmaster.ca.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The recommendations are supported by existing guidelines, randomized trials, and systematic reviews.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Patients with cancer who are diagnosed with major depression may benefit from pharmacological or psychological interventions either alone or in combination, without evidence for the superiority of any specific treatment over another.

Potential Harms

- Clinicians must consider potential detrimental pharmacotherapy side effects, adverse drug interactions, and treatment compliance issues unique to the cancer context.
- In published studies, overall adverse effects were more common with mianserin compared with placebo ($p>0.05$). Emesis was more common with fluoxetine compared with placebo ($p=0.01$), and dry mouth was more likely with fluoxetine compared with desipramine ($p=0.008$). The new pharmacological intervention report identified in one systematic review found that 15% of the paroxetine group, 9% of the desipramine group, and 18% of the placebo group left the study early due to adverse events, the nature of which were consistent with the safety profiles for selective serotonin re-uptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs). Adverse events data were not captured for the studies of psychological interventions.
- See Section 1, Appendix 6 and Appendix 7 in the original guideline document for information on side effects and cautions regarding use of specific antidepressant drugs and antidepressant-oncology drug interactions, respectively.

Contraindications

Contraindications

- Avoid bupropion in those with central nervous system cancers.
- Avoid psychostimulants or tricyclic antidepressants (TCAs) in cardiac disease.

See Section 1, Appendices 6 and 7 in the original guideline document for information on contraindications for specific antidepressant drugs.

Qualifying Statements

Qualifying Statements

- Care has been taken in the preparation of the information contained in this document. Nonetheless, any person seeking to apply or consult the report series is expected to use independent medical judgment in the context of individual clinical circumstances or seek out the supervision of a qualified clinician. Cancer Care Ontario (CCO) makes no representation or guarantees of any kind whatsoever regarding their content or use or application and disclaims any responsibility for their application or use in any way.
- See the original guideline document for qualifying statements related to each recommendation.

Limitations of the Evidence Base

The literature on managing depression in patients with cancer presents many challenges. As mentioned, the literature includes many studies of depression interventions in patients with subthreshold levels of depression in which it is difficult to observe an effect of treatment due to floor effects. Therefore, the Working Group chose to limit the eligibility of studies to those in which patients met validated thresholds for major depression or a depressive disorder. Many systematic reviews were found that had overlapping scope and slight variations in inclusion criteria, so the Working Group decided to use randomized controlled trials (RCTs) as the evidence base, rather than trying to resolve the results of many similar systematic reviews. Trials that are underpowered to detect differences between treatment and control groups are a major issue. Some studies reported difficulties accruing sufficient sample sizes to achieve adequate power, a problem that is also reflected in the relative absence of new placebo-controlled studies. The strong placebo effects in depression intervention studies result in positive findings for most interventions, making effect size measured as the standardized mean difference (SMD) compared with placebo the gold standard for the effectiveness of an intervention. One of two pharmacological studies published since the last version of this guideline was underpowered to detect differences due to recruitment challenges, and placebo effects in psychological intervention studies are arguably even more powerful and difficult to control. Placebo effects are a well-recognized confounding variable in depression treatment studies, accounting for almost 40% of symptom reduction in control groups, compared with the average 50 to 60% symptom reduction with antidepressants or psychotherapy.

Other methodological issues were the inconsistency with respect to study populations, with some studies including patients with adjustment disorder, and multiple comparisons using several different assessment scales. A further confounding variable is the use of only depression rating scale scores for study entry due to the uncertainty regarding appropriate cut-off thresholds for depression in patients with cancer, whose scores may be elevated by cancer-related symptoms. Validated screening and case-finding cut-offs used in psychiatric populations are generally too low

to represent, with specificity, major depression in patients with cancer.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Clinical Algorithm

Quick Reference Guides/Physician Guides

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

End of Life Care

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Li M, Kennedy EB, Byrne N, Gerin-Lajoie C, Green E, Katz MR, Keshavarz H, Sellick SM, Management of Depression in Patients with Cancer Expert Panel. The management of depression in patients with cancer. Toronto (ON): Cancer Care Ontario (CCO); 2015 May 11. 96 p. (Program in Evidence-Based Care Guideline; no. 19-4). [170 references]

Adaptation

The guideline recommendations are adapted from the following:

- National Institute for Health and Clinical Excellence. Depression in adults with a chronic physical health problem. NICE clinical guideline 91

(CG91), 2009.

- Rayner L, Higginson I, Price A, Hotopf M. The management of depression in palliative care. European Palliative Care Research Collaborative, 2010.

Date Released

2015 May 11

Guideline Developer(s)

Program in Evidence-based Care - State/Local Government Agency [Non-U.S.]

Guideline Developer Comment

The Program in Evidence-based Care (PEBC) is a Province of Ontario initiative sponsored by Cancer Care Ontario (CCO) and the Ontario Ministry of Health and Long-Term Care.

Source(s) of Funding

The Program in Evidence-based Care (PEBC) is a provincial initiative of Cancer Care Ontario (CCO) supported by the Ontario Ministry of Health and Long-Term Care. All work produced by the PEBC is editorially independent from the Ontario Ministry of Health and Long-Term Care.

Guideline Committee

Management of Depression in Patients with Cancer Working Group

Management of Depression in Patients with Cancer Expert Panel

Composition of Group That Authored the Guideline

Authors: M. Li, E.B. Kennedy, N. Byrne, C. Gerin-Lajoie, E. Green, M. R. Katz, H. Keshavarz, S. M. Sellick, and the Management of Depression in Patients with Cancer Expert Panel

Financial Disclosures/Conflicts of Interest

In accordance with the Program in Evidence-based Care (PEBC) Conflict of Interest (COI) Policy, the guideline authors, Management of Depression in Patients with Cancer Expert Panel members, and internal and external reviewers were asked to disclose potential conflicts of interest.

NB reports partnership in a private practice that provides psychological intervention for cancer patients and others for which income exceeds \$10,000 annually. NB is also a member of the Board of Directors of the Canadian Association of Psychosocial Oncology. CGL reports a completing a book review for the *Canadian Journal of Psychiatry* on "Depression and Cancer" by David Kissane, published 2011. ML reports authorship on a narrative review on this topic published in the *Journal of Clinical Oncology*, as well as creating an International Psycho-Oncology Society webcast and providing DeSouza content expertise on this topic. MK reports receiving consulting income from Lundbeck, Pfizer, Sunovion, Lilly, Janssen, Shire, and Bristol Myers Squibb within the past five years. The other guideline authors do not report any relevant conflicts of interest.

The declared conflicts did not disqualify any individuals from performing their designated role in the development of this guideline, in accordance with the PEBC COI Policy. To obtain a copy of the policy, please contact the PEBC office by email at ccopgi@mcmaster.ca.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Rodin G, Katz M, Lloyd N, Green E, Mackay JA, Wong R, Supportive Care Guidelines Group. The management of depression in cancer patients: a clinical practice guideline. Toronto (ON): Cancer Care Ontario (CCO); 2006 Oct 17. 39 p. (Evidence-based series; no. 13-6). [78 references]

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This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the [Cancer Care Ontario \(CCO\) Web site](#) .

Availability of Companion Documents

The following are available:

- The management of depression in patients with cancer. Summary. Toronto (ON): Cancer Care Ontario (CCO); 2015 May 11. 29 p. Available from the [Cancer Care Ontario \(CCO\) Web site](#) .
- Program in Evidence-based Care handbook. Toronto (ON): Cancer Care Ontario (CCO); 2012. 14 p. Available from the [CCO Web site](#) .

In addition, Appendices 1-7 of the [original guideline document](#) contain a number of practical tools for management of depression in patients with cancer.

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI on March 27, 2008. This summary was updated by ECRI Institute on January 8, 2010 following the U.S. Food and Drug Administration advisory on Norpramin. This summary was updated by ECRI Institute on August 24, 2016.

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